Wound Care Program for Nursing Assistants - Prevention 101

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Outline/Agenda

At completion of this webinar, the participant will:

- Define the role of the Nursing Assistant in wound prevention;
- Demonstrate appropriate skin care for different skin presentations;
- Describe role of nutrition and hydration;
- Identify all major pressure points;
- Demonstrate different methods of offloading and prevention of shear;
- Identify different types of compression and demonstrate safe application;
- Describe ways to assist the patient with adequate elevation;
- Clearly verbalize changes in your patient that are outside your Scope of Practice, and when to request nurse assessment.
LNA role in wound care and prevention

Understanding and staying within your Scope of Practice is YOUR responsibility. It is there to maintain patient safety and protect you!

Licensed Nursing Assistants in NH may:
- provide ‘routine, stable’ wound care
- apply medicated lotions, ointments, and creams related to skin care.
Nursing Assistant Decision Tree

Taking care of YOU…

- Your role is KEY to maintaining many of our patients at home!

- Proper ‘tools for the job’
  - PPE
  - Ergonomics
  - Environment
Losing Your Marbles...
Skin Care
Prevention 101
Quality Skin Care: First Line of Defense

Some basic rules:

- Hydration is KEY
- Moisturize dry areas
- Dry moist areas
- Inspect your patients’ skin with all care

*Never between toes!*

Avoid: harsh fragrances, irritating antiseptics, hydrogen peroxide, or other harsh chemicals to clean or disinfect the skin.
Skin Conditions

- Intact: unscented lotion or cream daily or with bathing.

- Dry/Cracked: Unscented, hypoallergenic cream nightly or after bathing. Leave ‘streaky’; allow 15 minutes to absorb.

- Denuded: Barrier cream or barrier ointment with all toileting/continence care: DO NOT SCRUB OFF!

- Other conditions: yeast/candiasis, aging skin…
Skin Care: Products

- Unscented/hypoallergenic lotions & creams:
  - These are generally without color, and tend not to cause reaction in sensitive/previously injured skin.

- Barrier creams/ointments:
  - Form a barrier to protect against skin damage from moisture.
  - Use with all incontinence care
  - Don’t scrub it off!
Lotion vs cream: more bang for your buck!

- Lotion: pump/tube
- Cream: pot/(sometimes) tube
- Cream is thicker: it has less water content, so stays on skin longer!
So you're all thinking...

- Moist folds!
  - Powders, not creams in already moist areas
  - Cheap/fast/no orders: clean white cotton t-shirt
    - Please: inform your nurse. Occurrence requires assessment.

- Specialty products/requiring an order: Interdry AG, UltraSorbs

Antimicrobial!

Increased absorbancy!
How To: Wicking moist folds

Note: cotton t-shirt wicking should be washed in hot water and mild detergent, and dried thoroughly before reuse.
Offloading

Prevention 101
Offloading

- The marble…

- Is your patient able to reposition independently?
  - The Rule of 15/2

- What goes in must come out…

- Wrinkles & bunching

- Check those shoes!
Key areas to offload:
Offloading

- **Relieve pressure on vulnerable areas** ~
  - Reposition the patient every two hours when in bed.
  - Encourage/assist the patient to shift their weight every 15 minutes.
  - Use pillows or other offloading devices to raise the patient’s arms, legs, buttocks and hips.
  - Except with meals, keep the head of the bed at less than 30°

- **Reduce shear and friction** ~
  - Avoid dragging the patient across the bed sheets: lift/Hoyer the patient or have the patient assist you, if able, by bending knees and raising his or her body.
  - Keep the bed free from crumbs and other particles that can rub and irritate the skin.
  - Use offloading boots, pillows, or elbow pads to reduce friction on heels and elbows.
  - If using a hospital bed, use the knee gatch!
Offloading

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Offloading: what NOT to do…

- More is not better!
- The old ‘egg crate’
- The dreaded Donut
- Rolled towels vs pillows
Offloading products

- The Waffle cushion
- Offloading boots
- A word on sleep surfaces…
The versatile Waffle...

- **Check the fill:**
  - Keep your hand flat, do not bend fingers under the WAFFLE Cushion.
  - While patient is seated on the WAFFLE Cushion, slide your hand, palm side up, under the cushion and between patient’s legs.
  - The ability to lift the fingers upward before coming into contact with the patient's body is an indicator of having the correct amount of air.
  - The purpose of the hand check is to ensure there is enough air in the cushion, thereby providing pressure redistribution for the patient.
  - Your cushion will appear to be only 60% inflated.
  - Cushion is properly inflated when you can easily roll one side just past the first set of holes.
  - Weight tested up to 300 lbs, bariatric support is also available.
Pin the Pressure Points:
Nutrition/Hydration

Why is this so important?

- Poor nutrition weakens skin and causes muscle loss, making pressure points more prominent.
- Protein helps wounds heal.
- Dehydration thins skin, making it more susceptible to tears.
- The body needs fluid to maintain temperature, remove waste, and lubricate joints.
Nutrition/Hydration

- **Nutrition**: should be well balanced, with adequate protein, unless otherwise instructed.

- **Hydration**: 6-8 8oz glasses daily, unless otherwise instructed.

- There are many diseases and disorders that require a specific diet, and may require minimizing protein or restricting fluids:

  **Ask your nurse for specifics on each patient!**
Compression

- Application of daily compression
  - Compression stocking
  - Tubular compression stocking
  - CircAid
  - Aero Wrap
Compression: When NOT to apply

- Patient reports or demonstrates increased leg pain
- Signs of impaired circulation
  - Cold, blue, white
- Changes in swelling/edema
- If there aren’t orders in place
Compression products:

- Tubular elastic support bandage [Tubigrip, Spandigrip, MediChoice, etc.]
- Compression stockings
- A brief word on CircAid, Aero Wrap, & other alternative compression
- Nurse- or MD-applied compression: When to make The Call
Compression: Outside your SoP

- ACE wraps [except for amputation site stumps]
- Lymphedema wrap application
- Coban self-adherent wrapping
- UNNAs boots
- Multilayered stretch wraps

Your role:
- Confirm they haven’t slipped or bunched,
- Patient isn’t complaining of increased pain,
- Toes aren’t blue, white, or cold.

**If any of these DO occur, contact your nurse/supervisor**
Elevation

- Why?
  - Decreases swelling
  - Offloads feet
  - Encourages patient to pace themselves
- Daily preventative elevation for edema management
  - Above the heart
  - Protect fragile heels
- When to report to nurse/supervisor
  - Increased pain
  - Increased edema/weeping legs
Elevation

- Daily preventative elevation for edema management
  - Above the heart
  - Anything is better than nothing
  - Protect fragile heels

- When to report to nurse/supervisor
  - Increased pain
  - Increased edema/weeping legs
Elevation...
Prevention 101

- TEST
- COMPETENCY
Competency:

Offloading
Offloading

- Waffle cushion
- Appropriate positioning
Competency:

Proper elevation for Venous Disease
Competency:

Tubular Compression Application
Check your knowledge:

Pressure point identification
Thank you!
Questions

- A bedbound patient should be turned every 3-4 hrs ___ 1-2 hrs ___ after meals
- What method/device off-loads pressure?
  Tubular compression stocking/ waffle boot/donut cushion
- Feet should be soaked. _____ t _____ f
- A patient with arterial disease shouldn’t wear compression stockings. T_____ f_____
- Barrier cream should be removed completely before applying again T/F